Medicaid Adjustment Request Form (ADJ-02)

Mail to: Adjustments
P.O. Box 241684
Montgomery, AL 36121-1684

Section I: Provider Pay-To Information

Provider Number _____

Provider Name _____

Address _____

_____

☐ Overpayment: Please process to correct the overpayment

☐ Underpayment: Please process to correct the underpayment

☐ Information correction: Please process to reflect the correct information

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Section II: Paid Claims Information

Please enter the following data from your remittance advice:

ICN Number: _____ Recipient Name: _____

Recipient ID Number: _____ EOP Date: _____

Date(s) of Service: _____

Billed Amount: _____ Paid Amount: _____

Section III: Description of the Problem

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

EDS Use Only

Date of Adjustment _____ Reviewer _____

Adjustment action:

_____ Pay
_____ Recoup

Revised 08-03